Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WESTLAKE ANESTHESIA GROUP (CRNA'S)
PO BOX 153105
LUFKIN TX 75915

Respondent Name
TX ASSOC OF COUNTIES RMP

Carrier's Austin Representative Box
Box Number: 01

MFDR Tracking Number
M4-13-3195-01

MFDR Date Received
JULY 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the request for reconsideration: "On FEBRUARY 21, 2013, we submitted an anesthesia charge for services rendered to [injured employee] on December 21, 2012, by fax #512-346-9321 which has been confirmed as the fax # for JI Specialty. (see fax confirmation sheet as proof of timely filing)."

Amount in Dispute: $1,190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2012	Anesthesia Services	$1,190.00	$373.05

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – Time limit for filing claim/bill has expired.

- 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds documentation, in the form of a fax confirmation sheet, to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
2. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute listed below:
   - CPT Code 01480-QX (CRNA service; with medical direction by a physician)

     Per 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

     The Division reviewed the submitted CMS-1500 (bill) and finds that the anesthesia was started at 13:34 and ended at 16:13, for a total time of 159 minutes.

     Per CMS one anesthesia time unit = 15 minutes of anesthesia time. The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth. Therefore, the requestor has supported 159 ÷ 15 = 10.60.

     To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance ÷ 50% (CRNA allowable).

     For a single anesthesia case involving both a physician medical direction service and the service of the medically directed CRNA, the payment amount for each service may be no great than 50 percent of the allowance. The total payment for both may not exceed the amount that would be paid had the service been furnished solely by the anesthesiologist.

     The Anesthesia Base Units for CPT code 01480 is 03; the 2012 DWC Conversion Factor is $54.86.

     The MAR for CPT code 01830-QX is: (Base Unit of 3 + Time Unit of 10.60) X $54.86 DWC conversion factor = $746.10 ÷ 50% = $373.05. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $373.05.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $373.05, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.